



## Complaint Form

**Mail Form and Information to:**

**Department of Health  
Facilities and Services Licensing/Investigations  
PO BOX 47852  
Olympia, WA 98504-7852  
Hotline: (800) 633-6828 Fax: (360) 236-2901**

Please provide as much information as you can on this form. This will help avoid delays in processing your complaint. You will be informed of any action taken by this office. Thank you.

Facility Information			
Name		Facility Phone	Facility Unit (Room #)
Address		City	State & Zip Code
Complainant Information			
Name		Relationship to Patient/Resident	
Address		Voice Phone (     )	2 <sup>nd</sup> Voice Phone (     )
		City	State & Zip Code
Patient/Resident Information			
Name		Voice Phone (     )	2 <sup>nd</sup> Voice Phone (     )
Address		City	State & Zip Code
		Patient DOB /     /	Patient Diagnosis
Today's Date /     /	Admission Date /     /	Discharge Date /     /	Incident(s) Date(s)



**Incident Description:** Please describe your specific complaint in the space below. Be as specific as possible. Please provide any supporting documentation. You may attach additional sheets if necessary.

[illegible]

<b>How was the patient affected by the incident?</b>		
<b>What prompted your call now ?</b>		
<b>Did you contact the facility?      Yes <input type="checkbox"/>      No <input type="checkbox"/></b>		
<b>Facility response:</b>		
<b>Participants: Please include the names of other patients/resident/ witnesses/staff members involved:</b>		
<b>Name:</b>	<b>Title:</b>	<b>Phone #:</b>
<b>Address:</b>		
<b>Name:</b>	<b>Title:</b>	<b>Phone #:</b>
<b>Address:</b>		
<b>Name:</b>	<b>Title:</b>	<b>Phone #:</b>
<b>Address:</b>		
<b>Name:</b>	<b>Title:</b>	<b>Phone #:</b>
<b>Address:</b>		



## Facilities and Services Licensing Investigations

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